

may withdraw the waiver and require that a State obtain initial approval of a system within two years of the date of waiver withdrawal.

[50 FR 30848, July 30, 1985, as amended at 54 FR 41974, Oct. 13, 1989]

433.131 Waiver for noncompliance with conditions of approval and re-approval.

If a State is unable to comply with the conditions of approval or of re-approval and the noncompliance will cause a percentage reduction in FFP, HCFA will waive the FFP reduction in the following circumstances:

(a) *Good cause.* If HCFA determines that good cause existed, HCFA will waive the FFP reduction attributable to those items for which the good cause existed. A waiver of FFP consequences of the failure to meet the conditions of approval or reapproval based upon good cause will not extend beyond two consecutive quarters.

(b) *Circumstances beyond the control of a State.* The State must satisfactorily explain the circumstances that are beyond its control. When HCFA grants the waiver, HCFA will also defer all other system deadlines for the same length of time that the waiver applies.

[50 FR 30848, July 30, 1985, as amended at 54 FR 41974, Oct. 13, 1989]

Subpart D—Third Party Liability

SOURCE: 45 FR 8984, Feb. 11, 1980, unless otherwise noted.

§ 433.135 Basis and purpose.

This subpart implements sections 1902(a)(25), 1902(a)(45), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements concerning—

(a) The legal liability of third parties to pay for services provided under the plan;

(b) Assignment to the State of an individual's rights to third party payments; and

(c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

[50 FR 46664, Nov. 12, 1985]

§ 433.136 Definitions.

For purposes of this subpart—

Private insurer means:

(1) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services included in the State plan; and

(3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

Title IV-D agency means the organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

[49 FR 8984, Feb. 11, 1980, as amended at 50 FR 46664, Nov. 12, 1985; 50 FR 49389, Dec. 2, 1985]

§ 433.137 State plan requirements.

(a) A State plan must provide that the requirements of §§ 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that—

(1) The requirements of §§ 433.145 through 433.148 are met for assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

(2) The requirements of §§ 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or

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payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.

[50 FR 46665, Nov. 12, 1985, as amended at 55 FR 48606, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 60 FR 35502, July 10, 1995]

§ 433.138 Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) *Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.* (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with HCFA or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) *Obtaining other information.* Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) *Exchange of data.* Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under § 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in § 435.4 of this chapter and from the SSA wage and earnings files data as specified in § 435.948(a)(2) of this chapter, the agency must—